Deputy Sheriff
Booklet 3

PacifiCare Medical/Vision

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of PacifiCare Coverage

Here are a few highlights of your coverage under the PacifiCare plan:
- You do not pay an annual deductible under this plan (unless you live outside the PacifiCare service area; see "Out-of-Area Coverage")
- You pay copays for office visits, prescription drugs and emergency room care (if not admitted)
- You must select a primary care provider (PCP) from the PacifiCare network
- Your PCP provides and coordinates all services through the PacifiCare network, unless you require emergency care
- Network benefits are generally paid at 100% after the copays.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:
- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the full monthly cost of coverage for you and eligible family members you enroll under this plan.

When you receive medical care, you pay:
- Any required copays at the time of service (and deductible and coinsurance if living outside the service area)
- Amounts in excess of usual, customary and reasonable (UCR) rates
- Expenses for services or supplies not covered by the plan.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants (see "Transplants" in the "Covered Expenses Under PacifiCare" section).

If you end employment with King County, please refer to "Certificate of Coverage" in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections after the table contain more details.

Plan Feature	PacifiCare
Provider choice	You choose a PacifiCare PCP who provides and coordinates services through the PacifiCare network; no non-network coverage unless indicated
Annual deductible	None (unless you live outside the PacifiCare service area)
Copays	See "Summary of Covered Expenses" for amounts
After the copays, the plan pays most covered services at this level ...	100% network
Until you reach your annual out-of-pocket maximum...	$500/person, $1,500/family for network care and limited emergency/out-of-area non-network care
Then, most benefits are paid for the rest of the calendar year at ...	100% network
Lifetime maximum	No limit except for transplant benefits

► Network Providers

PacifiCare is licensed by the Office of the Insurance Commissioner to arrange for medical and hospital services in certain geographic areas of Washington. These service areas are defined by ZIP codes. Please contact PacifiCare for service area information (see the Resource Directory booklet).

All providers (hospitals, clinics, doctors and other health care professionals) who make up the PacifiCare network are carefully screened by PacifiCare. To be considered for the network, hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health professionals must also complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. For a list of network providers, contact PacifiCare (see the Resource Directory booklet).

► Out-of-Area Coverage

Out-of-area coverage is available under this plan, as described below:

- For emergency and urgent care anytime you're outside the PacifiCare service area (see "Emergency Care" and "Urgent Care" in the "Covered Expenses Under PacifiCare" section)
- If you live outside the PacifiCare service area for at least nine months out of a year and are more than 30 miles from the nearest PCP, you must contact PacifiCare to set up an out-of-area coverage plan (see the Resource Directory booklet). Under PacifiCare's out-of-area coverage plan:
  - You pay a $200 per person, $600 per family annual deductible (the deductible doesn't apply to prescription drugs)
  - You make an appointment with a licensed provider
  - The plan pays 80% for most services; if you reach a $1,000 per person, $2,000 per family out-of-pocket maximum, the plan pays 100% for most covered expenses the rest of the year
  - You must obtain preauthorization for certain procedures (see "Obtaining Preauthorization")
  - Depending on your provider, you may have to pay the bill in full and file a claim for reimbursement
  - You're responsible for any charges that exceed usual, customary and reasonable (UCR) rates.

If you live outside the PacifiCare service area and qualify for out-of-area-coverage, you don't need to:

- See PacifiCare Behavioral Health providers for mental health care or chemical dependency treatment, but you or your provider must obtain preauthorization by contacting PacifiCare Behavioral Health (see the Resource Directory booklet).
- Fill your prescriptions at a network pharmacy, but must pay for the prescription in full and file a claim for reimbursement; the plan pays 100% minus the copay.

► Selecting a Primary Care Provider

Your primary care provider (PCP) is your personal doctor and the starting point for all your medical care. To receive benefits, your PCP must provide or coordinate all of your care (with the exceptions described in the "Accessing Care" section of this booklet).

Each family member may have a different PCP. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP arranges it.

You and your covered family members must select PCPs when you enroll; otherwise PacifiCare will choose one for you. Except for situations where you may self-refer or in urgent or emergency situation, if you see another health care provider without the approval of your PCP, participating medical group (the group your PCP is affiliated with) or PacifiCare, services will not be covered. Contact PacifiCare for a list of PCPs (see the Resource Directory booklet). The name of your PCP will be printed on your ID card.

Continuity of your care is important and easier to achieve if you establish a long-term relationship with your PCP. However, you may find it necessary to change providers. Before you see another PCP, you must contact PacifiCare. You may see your new PCP the first of the month following the change.

► Selecting a Primary Hospital

When you choose a PCP, you also choose your primary hospital – the hospital the PCP is affiliated with and where you'll go for most hospital services. To confirm the primary hospital you have chosen, ask your PCP or contact PacifiCare (see the Resource Directory booklet).

► Specialists

Your PCP is responsible for determining when it's medically necessary for you to see a specialist, except for visits to obstetrical and gynecological providers (described in this section) and certain specialists as described in the "Accessing Care" section of this booklet. If your PCP determines you need a referral, he/she submits a request to your participating medical group or PacifiCare; then a Utilization Review Committee reviews the request. If approved by the committee, the referral is authorized and may require your specialist to provide your PCP with regular reports on your treatment and condition. If the request is not approved, the referral is denied; in this event, you can request an appeal of the decision (see "If You Have a Problem").

Getting OB/GYN Care Without a Referral. Women may receive outpatient obstetrical and gynecological services directly – from a participating PacifiCare OB/GYN, family practice provider or surgeon identified by PacifiCare as providing these services – without preauthorization or PCP referral. In all cases, the doctor must be affiliated with PacifiCare (or preauthorized/referred); otherwise, you're financially responsible for the services.

All OB/GYN inpatient or hospital services, except emergency or urgent care, need to be preauthorized by your PCP, participating medical group or PacifiCare.

To receive OB/GYN services:
- Call the number on the back of your ID Card and request the names and phone numbers of the OB/GYNs affiliated with PacifiCare
- Schedule an appointment with your selected participating OB/GYN.

If your condition requires follow-up care, your OB/GYN contacts your PCP about your condition, recommended treatment and any women's health care services involving hospitalization.

► Accessing Care

Generally, to receive benefits:
- You make an appointment with your PCP

- You pay a $5 office visit copay at the time you receive health care services
- Your PCP obtains preauthorization for your care as necessary
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

For some benefits, you may receive services from a PacifiCare network provider without PCP referral (see "Covered Expenses Under PacifiCare"):
- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Chiropractic care (must see a PacifiCare network provider and copay is higher when you self-refer)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women's health services (such as maternity care, reproductive health services and gynecological care).

For emergency care, you may see any provider (see "Emergency Care" in the "Covered Expenses Under PacifiCare" section).

► Obtaining Preauthorization

Generally, your PCP or specialist obtains preauthorization for services that require it through PacifiCare or your participating medical group. However, you must obtain preauthorization if you don't see or coordinate with your PCP for these services:
- Chemical dependency treatment
- Mental health care
- Women's health care services involving hospitalization or surgery.

Although you don't need preauthorization for accidents or emergencies (including detoxification), you, a family member or hospital staff member are expected to call PacifiCare or your PCP within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

To obtain preauthorization for:
- Care other than mental health care and chemical dependency treatment, have your provider call PacifiCare at 1-800-932-3004 (7 a.m.-9 p.m. Pacific time, Monday-Friday)
- Mental health care or chemical dependency treatment, you or your provider must call PacifiCare Behavioral Health at 1-800-577-7244 (24 hours a day, seven days a week).

When you call for preauthorization, be prepared to give:
- Your name
- Your group number (801012 retirees, 801013 active employees or 801723 COBRA participants) and member number (on your ID card)
- The reason for your call.

If you don't obtain preauthorization as described above, your care will not be covered.

► Second Opinions

You have the right to a second opinion regarding any medical diagnosis or treatment plan. Requests must be submitted to your participating medical group or PacifiCare (your PCP can advise you which one). The second opinion will be provided by an appropriately qualified health care professional of your choice from within the:
- Participating medical group (the group your PCP is affiliated with) for care recommended by your PCP
- PacifiCare network for care recommended by a specialist or PCP not affiliated with a participating medical group.

You're responsible for outpatient copays to the provider who gives you your second medical opinion.

The second opinion describing recommended procedures and tests will be made available to you and your treating provider. If it includes the recommendation for a particular treatment, diagnostic test or service PacifiCare covers

and is determined to be medically necessary by your participating medical group or PacifiCare, the recommended action will be covered. The fact an appropriately qualified provider gives a second opinion and recommends a particular treatment, diagnostic test or service doesn't necessarily mean it is medically necessary or covered.

► Annual Deductible

There is no annual deductible under the PacifiCare plan unless you live outside the service area (see "Out-of-Area Coverage").

► Annual Out-of-Pocket Maximum

The out-of-pocket maximum is generally the most you pay toward copays each plan year. This means once you reach your out-of-pocket maximum, the PacifiCare plan pays 100% of most covered expenses for the rest of the calendar year.

The following do not apply to the out-of-pocket maximum:
- Amounts in excess of UCR rates
- Charges beyond benefit maximums
- Chiropractic care copays
- Emergency room copays
- Expenses for services and supplies not covered by the plan
- Mental health care copays
- Prescription drug copays.

► Lifetime Maximum

There is no lifetime maximum under the PacifiCare plan, except for transplant benefits (see "Transplants" in the "Covered Expenses Under PacifiCare" section).

Covered Expenses Under PacifiCare

► Summary of Covered Expenses

The following table summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related copays, maximums and limits. To receive most services and supplies, a PCP referral is required. For more details, see "Accessing Care," the sections after the table and "Expenses Not Covered."

Covered Expenses	PacifiCare
Additional benefits for LEOFF 1 employees	Not covered
Alternative care	100% after $5 copay/visit when referred by PCP
Ambulance services	100%
Chemical dependency treatment	100% for inpatient 100% for outpatient $12,000 maximum/24 consecutive calendar months (maximum subject to annual adjustment)
Chiropractic care	100% after $5 copay/visit when referred by PCP 100% after $10 copay/visit up to 33 visits/year when self-referred (must see a network provider)
Circumcision (for newborns)	100%

Covered Expenses	PacifiCare
Diabetes care training	100%
Durable medical equipment, prosthetics and orthopedic appliances	100%
Emergency care (in an emergency room)	100% after $50 copay/visit (waived if admitted)
Family planning	100%
Growth hormones	100% when preauthorized
Home health	100% up to 130 visits/year
Hospice care	100% (6-month lifetime maximum)
Hospital care	100% ($50 copay/visit for emergency care, waived if admitted)
Infertility treatment	Not covered
Injury to teeth	100%
Inpatient care alternatives	100%
Lab, x-ray and other diagnostic testing	100% (includes mammograms, prenatal tests)
Manipulative therapy (including chiropractic services)	See chiropractic care
Maternity care - delivery and related hospital care	100%
Maternity care - prenatal and postpartum care	100% after $10 copay/pregnancy
Mental health care	100% for inpatient up to 30 days/year; 100% for residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) 100% after $5 copay/visit for outpatient up to 30 visits/year
Neurodevelopmental therapy for covered family members age 6 and under	100% for inpatient 100% after $10 copay/visit for outpatient up to 60 visits/year when referred by PCP and preauthorized
Newborn care (up to at least 21 days as mandated by state law)	Covered at various levels; call plan for details
Physician and other medical/surgical services	100% inpatient 100% outpatient after $5 copay/visit
Phenylketonuria (PKU) formula	100%
Prescription drugs up to 30-day supply through network pharmacies	100% after $5 copay/prescription or refill for generic drugs and insulin (brand-name drugs are covered only when generic not available)
Prescription drugs up to 90-day supply through mail order	100% after $10 copay/90-day supply for generic drugs and insulin (brand-name drugs are covered only when generic not available)
Preventive care (such as routine exams and immunizations)	100% after $5 copay/visit
Radiation therapy, chemotherapy and respiratory therapy	100%
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% depending on services provided; copays may apply
Rehabilitative services	100% for inpatient 100% after $10 copay/visit for outpatient up to 60 days or visits/year when referred by PCP and preauthorized

Covered Expenses	PacifiCare
Skilled nursing facility	100% up to 150 days lifetime maximum/condition (must be instead of a hospital stay) when referred by PCP and preauthorized
Smoking cessation	100% after $20 copay/network program 100% after $20 copay for each 4-week supply of nicotine replacement when prescribed by PCP (90-day treatment maximum)
Sterilization procedures	100% (see "Family Planning")
Supplemental accident benefits	Not covered
Temporomandibular joint (TMJ) disorders	Not covered
Transplants (certain transplants/services only)	100% up to $500,000 lifetime maximum Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or emergency
Urgent care	100% after $5 copay/visit
Vision care eye exams (comprehensive exam and prescription for eyeglasses are covered; dilated fundus exam included when deemed necessary by provider)	100% for 1 exam every 12 months from network provider (Cole Vision Service) 100% up to $40 for 1 exam every 12 months from non-network provider
Vision care lenses (single vision, bifocal, trifocal or lenticular)	100% for 1 pair of lenses every 12 months from network provider(Cole Vision Service) 100% up to $100 for 1 pair of lenses every 12 months from non-network provider
Vision care frames	100% up to $150 retail value for 1 pair of frames every 24 months from network provider(Cole Vision Service) 100% up to $100 for 1 pair of frames every 24 months from non-network provider
Vision care contact lenses (instead of glasses)	100% up to $150 retail value for 1 pair of contacts every 24 months from network provider (Cole Vision Service) 100% up to $100 for 1 pair of contacts every 24 months from non-network provider
Vision care – additional services	Unlimited additional pairs of glasses/contact lenses and lens options at discount from network provider (Cole Vision Service) No extra charge for high powered prescriptions, oversized lenses or prism Lasik Discount Program from Cole Vision Service Mail order contacts from Contact Direct

► Alternative Care

You must have a PCP referral to receive alternative care services, which include but are not limited to the professional services of a:

- Licensed acupuncturist
- Licensed naturopath
- Massage therapist (not covered for recreational, sedative or palliative reasons; remember, all care must be medically necessary).

This plan does not cover:

- Herbal preparations

- Nutritional supplements
- Teas.

► Ambulance Services

Services of an ambulance company are covered to transport you to a facility equipped to treat your condition in a medically necessary emergency, but only when other modes of travel would put you in danger.

► Chemical Dependency Treatment

The plan provides for chemical dependency treatment by an approved alcoholism or drug treatment program.
- "Medically necessary treatment of chemical dependency" is defined in the Patient Criteria for the Treatment of Substance Related Disorders II published in 1996 by the American Society of Addiction Medicine
- "Approved alcoholism or drug treatment program" is defined as any hospital or public or private treatment program that provides services for the treatment of chemical dependency, operates under the direction and control of the state and is approved by PacifiCare Behavioral Health.

No referral is required to access chemical dependency treatment, but it must by preauthorized by PacifiCare Behavioral Health and provided by a PacifiCare Behavioral Health provider to be covered (except in an emergency). Your PCP can arrange chemical dependency services or you may call PacifiCare Behavioral Health at 1-800-577-7244.

Chemical dependency services are provided up to the benefit maximum of $12,000 in any consecutive 24 months. Covered services include:
- Family therapy for the patient and covered family members
- Individual and group therapy
- Inpatient care, including medical detoxification associated with acute alcohol, drug or other substance abuse
- Outpatient care
- Residential or day treatment.

In addition to the benefits listed in "Expenses Not Covered," the chemical dependency benefit does not cover:
- Confinement, treatment, services, or supplies not preauthorized by PacifiCare Behavioral Health, or supplied by a non-PacifiCare Behavioral Health provider, even if referred by the PCP, except emergency care
- Treatment for addiction to, or dependency on, tobacco, nicotine, or caffeine
- Volunteer support groups.

► Chiropractic Care

You must see a network chiropractor for care; you do not need a PCP referral for up to 33 visits a year.

The plan covers services of licensed chiropractors, limited to:
- Diagnostic lab services directly related to your spinal care treatment
- Full spinal x-rays
- Noninvasive spinal manipulations.

► Circumcision

See "Newborn Care."

► Diabetes Care Training

The plan covers diabetic care training when prescribed by your PCP.

► Durable Medical Equipment, Prosthetics and Orthopedic Appliances

Durable medical equipment and prosthetics are covered if they have a specific therapeutic purpose in treating your illness or injury and are:
- Designed for prolonged use
- Prescribed by your provider
- Primarily and customarily used only for medical purposes.

Covered items include:
- Artificial limbs and eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses and braces
- Diabetic equipment such as blood glucose monitor, diabetic shoes and inserts, and insulin pumps not covered under the prescription benefit (excluding batteries) when ordered by a provider to treat diabetes
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Ostomy supplies
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord (and if other accepted treatment has been unsuccessful)
- Pressure stockings (when medically necessary)
- Rental or purchase (approved by PacifiCare) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition.

► Emergency Care

An emergency medical condition exists when symptoms and pain are severe enough that a reasonable person might expect loss of life or limb, or serious harm to his/her health if the condition is not treated immediately (see the Glossary booklet for more details). Examples of emergency medical conditions include, but are not limited to:
- Bleeding that won't stop
- Chest pain
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

You don't need a PCP referral to receive emergency care. If you need emergency care:
- Call 911 or go to the nearest hospital emergency room immediately
- When you arrive, show your ID card
- Call PacifiCare or your PCP within 24 hours of receiving emergency care so your PCP can coordinate your care and schedule any follow-up treatment; if you, the hospital staff or someone else on your behalf doesn't contact PacifiCare within 24 hours, you may be responsible for all costs incurred before you call.

Once the emergency medical condition stabilizes, you may require more care before being discharged. In that case, the treating provider will contact your participating medical group or PacifiCare to obtain authorization. PacifiCare may, in certain circumstances, to transfer you to a network hospital instead of authorizing post-stabilization services at the treating facility.

Regardless of where you are in the world after being discharged from a hospital for emergency care, contact your PCP or PacifiCare's Utilization Management Department to authorize follow-up out-of-area care (call 1-800-762-8456 weekdays, 8 a.m.-5 p.m. Pacific time).

► Family Planning

Covered family planning expenses include:
- Intrauterine birth control devices (IUDs)
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The plan does not cover:
- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit.

► Growth Hormones

The plan covers growth hormones when determined medically necessary (like all covered services and supplies) by your PCP and are preauthorized by your participating medical group or PacifiCare.

► Home Health Care

You must have PCP referral to receive home health care services. Services are covered if:
- Provided and billed by a licensed Washington State home health care agency
- Part of a home health care plan, and
- Care takes the place of a hospital stay.

Services and prescription drugs administered and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health agency.

Covered services include:
- Nursing care
- Occupational therapy
- Physical therapy
- Prescription drugs, if used during a period of covered home health agency care (prescription drugs included in a home health treatment plan don't require a copay)
- Respiratory therapy
- Restorative speech therapy
- Restorative therapy.

The following services are not covered:
- Custodial care, except by home health aides as ordered in the approved plan of treatment
- House cleaning
- Services of any social worker
- Services or supplies not included in the approved treatment plan
- Services by a person who lives in your home or is a family member
- Travel costs or transportation services.

► Hospice Care

You must have PCP referral to receive hospice care. Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a provider, nurse, medical social worker and/or physical, speech, occupational or respiratory therapist.

Hospice care services are covered if:
- Provided and billed by a licensed Washington State hospice

- Part of a hospice care treatment plan and
- Care takes the place of a hospital stay.

Covered services include:
- Physician services
- Drugs and medications
- Emotional support services
- Home health and homemaker services under the supervision of a registered nurse
- Inpatient and outpatient hospice care
- Respite care for family members who care for the patient.

The following services are not covered:
- Bereavement or pastoral counseling
- Funeral arrangements
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Homemaker, caretaker or other services such as:
  - Sitter or companion services for the patient who is ill or other family members
  - Transportation
  - House cleaning or upkeep
  - More than 5 days of respite care in any 3-month period of hospice care
- Any services provided by members of the patient's family.

► Hospital Care

Your PCP must have a preauthorization from the participating medical group or PacifiCare to receive hospital care other than emergency care.

Covered inpatient hospital care includes:
- Newborn nursery care after covered childbirth, including circumcision
- Hospital services, such as:
  - Anesthesia and related supplies administered by hospital staff
  - Artificial kidney treatment
  - Blood, blood plasma and blood derivatives
  - Drugs
  - Electrocardiograms, physiotherapy and hydrotherapy
  - Operating rooms, recovery rooms, isolation rooms and cast rooms
  - Oxygen and its administration
  - Splints, casts and dressings
  - X-ray and lab exams
  - X-ray, radium and radioactive isotope therapy
- Intensive care or coronary care units
- Physician services
- Semiprivate room, meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate, unless no semiprivate room is available)
- Surgery and anesthesia administration.

Covered outpatient hospital care includes:
- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

► Infertility Treatment

The plan does not cover:
- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

► Injury to Teeth

Accidental injury to mouth and natural teeth is covered but limited to stabilization services received within six months of the injury. Benefits for dental accidents include a licensed dentist and provider licensed as a denturist for services within the scope of that license, if those services would have been covered if performed by a dentist.

► Inpatient Care Alternatives

Your PCP must preauthorize inpatient care alternatives through his/her participating medical group or PacifiCare. Your physician may develop a written treatment plan for an equally or more cost-effective setting than a hospital or skilled nursing facility. All hospital or skilled nursing facility benefit terms, maximums and limitations apply to inpatient care alternatives.

► Lab, X-ray and Other Diagnostic Testing

You must have a PCP referral to receive these benefits (remember, all must be medically necessary). Covered services include:
- Diagnosis and treatment of medical conditions of the eye by a Washington State-licensed optometrist or ophthalmologist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see "Vision Care")
- Hearing tests by a physician or licensed audiologist (see "Preventive Care" for more information on routine tests)
- Lab or x-ray services, such as ultrasound, mammograms, nuclear medicine, allergy testing
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders).

► Manipulative Therapy

See "Chiropractic Care."

► Maternity Care

You may self-refer for women's health care services (including maternity care), but inpatient hospital and outpatient surgery must be preauthorized.

Maternity care is covered if provided by a network:
- Physician
- Licensed registered nurse midwife
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:
- Pregnancy care
- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary for diagnosing congenital disorders of the unborn child
- Hospitalization and delivery, including delivery at a licensed birthing center (while preauthorization is necessary for hospital admissions, you don't need to preauthorize the length of the stay; see also "Hospital Care")
- Complications of pregnancy or delivery
- Postpartum care.

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

The plan does not cover:
- Home pregnancy tests
- Maternity services for dependent children.

Pregnancy to Preschool. This program helps women learn how to care for themselves during pregnancies and their new babies, complimenting prenatal medical care. To enroll, contact PacifiCare (see the Resource Directory booklet).

► Mental Health Care

PacifiCare, through PacifiCare Behavioral Health (PBH), provides a team approach to mental health care, working with behavioral and medical health care providers, contracted practitioners and community resources to restore and maintain your health and productivity.

Accessing Care. You do not need PCP referral for mental health care, but you must obtain preauthorization from PBH. Call PBH directly at 1-800-577-7244 or 1-800-833-6388 (TTY), 24 hours a day, seven days a week. You'll speak with a coordinator who checks your eligibility and gathers basic information. Depending on the type of help you need, a clinician may then talk with you about what provider and treatment are best for you. If you're referred to a PBH provider, you'll be authorized for a specific number of visits for a certain time. (For information about PBH participating providers or to obtain referrals for specialty care or after-hours care, call the numbers above.)

For services outside the service area, you're covered for emergencies only.

Emergency Care. In an emergency, do everything possible to ensure your physical safety; call 911 if necessary and get to a treatment center immediately. Then, within 48 hours of admission or as soon as reasonably possible, call PBH to coordinate services after emergency treatment. This may include transferring to a provider designated by PBH when you're stable and the transfer would not create an unreasonable risk.

If you get emergency treatment from a non-network provider, you may receive a bill. Send PBH a copy as soon as possible; PBH will not pay claims submitted more than a year after the date of service. Mail bills to:

PacifiCare Customer Service Department
PO Box 31053
Laguna Hills CA 92654-1053

You're responsible for any copays or coinsurance to the non-network provider.

What's Covered. To be covered, mental health care must be provided by a hospital, physician (such as a psychiatrist, psychologist or registered nurse), residential treatment facility, provider licensed or certified by the state as a mental health counselor or a community mental health agency, or state mental hospital.
- Inpatient care – Professional and facility services for inpatient diagnosis and treatment of mental illness are covered at 100% up to 30 days per year , subject to PacifiCare Behavioral Health's preauthorization requirements and use of network providers
- Outpatient care – Outpatient services for diagnosis and treatment of mental illness are covered at $5 copay per visit to 30 visits per calendar year, subject to the preauthorization requirements and use of network providers (the average number of outpatient visits is ten or less per episode of treatment).

Covered services include:
- Diagnostic testing to determine if a mental disorder exists
- Individual and group psychotherapy
- Lab services related to the covered provider's approved treatment plan

- Marriage and family therapy
- Physical exams and intake history
- Psychological testing
- Treatment for:
  - Diagnosed eating disorders
  - Mental disorders with a congenital or physical basis, such as Tourette's Syndrome (partial coverage may be under the medical services portion of this plan)
  - Self-inflicted harm, such as a suicide attempt.

What's Not Covered. The plan does not cover:
- Certain nonorganic therapies:
  - Bioenergetic therapy
  - Confrontation therapy
  - Crystal healing therapy
  - Educational remediation
  - Guided imagery
  - Marathon therapy
  - Primal therapy
  - Rolfing
  - Sensitivity training
  - Training analysis
  - Transcendental meditation
  - Z therapy or milieu therapy
- Certain organic therapies:
  - Aversion therapy (such as electric shock for behavior modification)
  - Carbon dioxide therapy
  - Environmental ecological treatment or remedies
  - Herbal therapies
  - Hemodialysis for schizophrenia
  - L-tryptophan or vitamins
  - Narcotherapy with LSD or sedative action electrostimulation therapy
  - Vitamin or orthomolecular therapy
- Court-ordered treatment (unless determined medically necessary by PacifiCare)
- Custodial care
- Long-term, insight-oriented psychotherapies designed to regress the patient emotionally or behaviorally
- Mental retardation care
- Pathological gambling treatment
- Personal enhancement or wellness development, or related programs not considered medically necessary
- Private rooms or private duty nursing
- Spiritual counseling or dance, poetry, music or art therapy
- Substance use/abuse conditions (except as described in "Chemical Dependency Treatment")
- Surgery as treatment for a mental disorder
- Treatment for:
  - Learning disabilities
  - Mental disorders related to sexual functioning or a sex change.

Without a psychiatric diagnosis of a mental condition, the plan also doesn't cover:
- Bereavement or catastrophic illness counseling
- Biofeedback
- Counseling for adoption, custody, family planning or pregnancy
- Sex therapy or sexual addiction therapy.

Information Disclosure. What you discuss with PBH is kept confidential; PBH provides information only to the professionals delivering your treatment. However, PBH requires its contracted mental health providers to provide it with information used to coordinate your care, including:

- Name
- Date of birth
- Five Axis/DSM-IV diagnosis codes
- Description of your mental status, including symptoms and degree of functional impairment
- History of substance abuse
- Medication information
- Information on any adjunctive services being performed.

Your Rights. PacifiCare and state law establish standards to:

- Make certain you know which services are covered under this plan and any limits
- Assure the competence and professional conduct of mental health service providers
- Guarantee your right to informed consent to treatment
- Protect the privacy of your medical information.

If you:

- Have a concern about the qualifications or professional conduct of your mental health service provider, contact the Washington State Health Department at 360-236-4902
- Want more details on your mental health benefits covered under this plan, or if you have a question or concern about any aspect of your benefits, contact Pacific Behavioral Health at 1-800-577-7244 or PO Box 3009, Hillsboro OR 97123-3009
- Would like to know more about your rights under the law or believe any of these mental health benefits do not conform to the plan or your rights, contact the Washington State Insurance Commissioner at 1-800-562-6900.

► Neurodevelopmental Therapy

To receive neurodevelopmental therapy, your PCP must obtain preauthorization from the participating medical group or PacifiCare. The plan covers neurodevelopmental therapy for covered family members six and younger, including:

- Hospital care
- Physician services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Maintenance of the patient when his/her condition would significantly worsen without those services
- Services to restore and improve function.

► Newborn Care

The plan covers newborns under the mother's coverage for the first 21 days, as required by Washington State law (see "Maternity Care"). To continue the newborn's coverage after 21 days, the newborn must be eligible and enrolled by the deadline as described in "Changes You May Make When a Qualifying Event Occurs" in the Important Facts booklet.

Postnatal hospital services are covered including:

- Circumcision if desired and performed in the hospital (if the circumcision is delayed by the physician during newborn hospitalization, it's covered at the first check-up when specified by the physician)
- Special care nursery.

► Physician and Other Medical/Surgical Services

The plan covers:

- Immunization agents or biological sera, such as allergy serum (immunizations for travel are not covered)

- Medical care in the physician's or alternative provider's office
- Nutrition counseling by a registered nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training; PacifiCare also has the right to ask for a second opinion to confirm the medical necessity of a proposed surgery or treatment plan).

► Phenylketonuria (PKU) Formula

The plan covers the medical dietary formula that treats phenylketonuria (PKU). You may order up to five cases in any month.

► Prescription Drugs

What's Covered. Prescription drugs are those that can be dispensed only by written prescription of a physician or someone else authorized to prescribe that drug under applicable state law. The plan covers:
- Birth control prescriptions (oral and injectable)
- Compound medications if the medication is made up of at least one prescription drug
- Devices and supplies that require a physician's prescription by law
- Glucagon emergency kits
- Glucose testing strips, injection devices and lancelets equaling the supply of covered insulin dispensed (you pay a prescription drug copay for these supplies in addition to the copy for the related drug)
- Insulin
- Needles and syringes equaling the supply of covered self-administered injectable drugs dispensed
- Other prescription drugs except those listed below.

What's Not Covered. The following prescription drugs and items are not covered:
- Appetite suppressants
- Drugs dispensed by a provider other than the mail order or network pharmacy (however, benefits may be available under other plan benefits, for example, hospital inpatient care)
- Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs
- Drugs prescribed by a provider not authorized by the state to prescribe the drugs or by a type of provider not covered under this plan
- Drugs used for cosmetic purposes
- Lifestyle drugs, such as for anti-obesity or anti-aging
- Nicotine-containing preparations in any form unless you're currently enrolled in the Free & Clear® StopSmoking℠ Program and authorized for nicotine patches
- Non-prescription drugs, other than insulin and prescription drugs equivalent to non-prescription drugs
- Prescription medicine for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy
- Therapeutic devices or appliances, support garments or other nonmedical supplies (except pressure stockings as described in "Durable Medical Equipment, Prosthetics and Orthopedic Appliances")
- Vitamins.

Preauthorization. PacifiCare reserves the right to require preauthorization by your physician and/or to limit the quantity of any prescription to meet these criteria:
- The prescription is for the treatment of a medical condition
- There is sufficient evidence to draw conclusions about the prescription's effect on the medical condition and health outcome
- Expected beneficial effects of the prescription outweigh expected harmful effects.

Preauthorization is also required when it's medically necessary to take medication above the preset limits for a particular condition/circumstance or if an exception to plan provisions is requested. Your provider may request

preauthorization by calling or faxing Prescription Solutions, PacifiCare's pharmacy benefit manager, Monday through Friday 6 a.m.-6 p.m. Pacific time (see the Resource Directory booklet).

Most preauthorization requests are processed within 24 hours unless your provider needs to submit more information about your diagnosis and medication history or to establish that the requested medication meets plan criteria.

You may appeal the decision by contacting PacifiCare (see "Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility").

Filling a Prescription. To obtain covered prescription drugs, you may use the mail order program (up to a 90-day supply) or network pharmacies (up to a 30-day supply). Prescriptions from any other pharmacies are covered only in an emergency or for out-of-area plan participants.

Mail Order Pharmacy. The first time you use the mail order pharmacy, fill out the patient information questionnaire on your prescription drug order form (contact PacifiCare for a form; see the Resource Directory booklet). Questionnaire information is maintained to help the pharmacist cross check future medicines for drug allergies.

Each time you order, send the order form with the written prescription and your payment directly to the mail order pharmacy address on the form. Or have your physician call in the prescription directly to the mail order pharmacy (the toll-free number is on the form).

Prescriptions are usually sent in 10 to 14 days. If you don't receive your medicine within 14 days or if you have questions, contact the mail order pharmacy (see the Resource Directory booklet).

Network Pharmacies. Network pharmacies dispense covered prescription drugs to PacifiCare participants at a discount and don't bill for any amounts over the copay. You may go to any network pharmacy; a PCP referral is not necessary. For a list of network pharmacies, contact PacifiCare (see the Resource Directory booklet).

To fill a prescription at a network pharmacy:
- Show your ID card to the network pharmacist each time you want a prescription filled or refilled (PacifiCare issues an ID card for each participant; if you buy covered drugs for your child, show the child's ID card)
- Pay the copay for each covered prescription or refill; there are no claim forms to submit (the network pharmacy bills the plan directly).

If you don't show your ID card and the network pharmacy cannot reach PacifiCare to confirm you're covered, no benefits will be provided except for these cases where you pay the pharmacy in full and submit the claim to PacifiCare:
- Emergency and urgent situations
- Out-of-area plan participants
- Participants who haven't yet received their ID cards.

Your Rights. State and federal law establish standards to assure safe, effective pharmacy services and guarantee your right to know what drugs are covered under this plan and what coverage limits are in your contract. If you:
- Would like a more detailed description of prescription benefits covered under this plan, or if you have a question or a concern about any aspect of your benefits, contact PacifiCare (see the Resource Directory booklet)
- Would like to know more about your rights under the law, or if you believe any of these prescription benefits do not conform to the terms of the plan or your rights under the law, contact the Washington State Insurance Commissioner at 1-800-562-6900.

► Preventive Care

You don't need a PCP referral before seeing a network provider for routine women's health care services (maternity care, reproductive health services and gynecological care). However, depending on the service (for example, if you need surgery), you may need preauthorization.

The following preventive care is covered:
- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Routine tests, such as physicals, Pap tests and hearing tests.

Mammograms are covered, but not under this preventive care benefit (see "Lab, X-ray and Other Diagnostic Testing"). Home cholesterol tests are not covered.

Preventive care benefits for children are payable according to the following schedule:

Age	Preventive Care
Birth to 1 year	Routine newborn care
1- 5 years	4 visits/year
6 - 12 years	1 visits/year

Additional Preventive Care and Health Management Programs. To help you stay healthy, PacifiCare makes these additional programs available to you (for details, contact PacifiCare; see the Resource Directory booklet):
- 24-Hour Health Information Line
- Free & Clear® StopSmoking℠
- Menopause: Understanding Your Options (online program)
- PacifiCare Perks (discounts for health and safety services/products)
- Pregnancy to Preschool (online program)
- Taking Charge of Diabetes®
- Taking Charge of Depression®
- Taking Charge of Your Health®.

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for radiation, chemotherapy and respiratory therapy prescribed by your PCP.

► Reconstructive Services

The following reconstructive services are covered when preauthorized by PacifiCare:
- Corrections of a child's congenital anomaly or disease
- Treatment for an injury within six months after the accident causing the injury, or as soon as medically feasible
- Reconstructive breast surgery and associated procedures following a medically necessary mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician, including:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
  - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas
  - Reduction mammoplasty when established medical criteria are met
  - Removal of breast implants.

► Rehabilitative Services

To receive rehabilitative inpatient or outpatient care, your PCP must obtain preauthorization from his/her participating medical group or PacifiCare.

Inpatient rehabilitative care is covered if:
- Medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- Provided in a hospital or Medicare-certified inpatient rehabilitative facility and
- Services could not be done in a less intensive setting and are ordered by a physician.

Covered services include physical, speech and occupational therapy as well as other services normally a part of inpatient rehabilitative care.

Outpatient rehabilitative care is covered if:
- Received from a provider licensed, registered or certified as required by the state to provide the services
- Medically necessary to restore or improve normal body functions lost or impaired due to illness or injury and
- Ordered by a physician.

Covered services include physical, speech and occupational therapy.

Outpatient rehabilitative care does not cover:
- Care to halt or slow further physical deterioration
- Self-help training (such as Outward Bound or recreational therapy)
- Evaluation or treatment of learning disabilities except as provided for neurodevelopmental therapy
- Social, vocational or cultural rehabilitation.

► Skilled Nursing Facility

To receive skilled nursing facility care, your PCP must obtain preauthorization from the participating medical group or PacifiCare. Skilled nursing facility services are covered if:
- Provided and billed by a licensed Washington State skilled nursing facility
- The care takes the place of a hospital stay.

Prescription drugs are covered when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care.

The following are not covered:
- Care or services not usually provided by a skilled nursing facility
- Confinement for developmental disabilities, mental conditions or primarily domiciliary, convalescent or custodial care
- Services or supplies not included in the approved treatment plan
- Services by a person who lives in your home or is a family member
- Travel costs.

► Smoking Cessation

You do not need a PCP referral to participate in PacifiCare's Free & Clear® StopSmoking℠ program; simply call 1-800-292-2336 (TTY 1-877-777-6534) to register.

The program provides materials and phone counseling to help you quit smoking at your own pace. If you're interested in tobacco cessation aids, you'll be screened when you enroll and advised (if eligible) how to obtain them (you must continue participating in the program to receive the aids).

► Sterilization Procedures

See "Family Planning."

► Transplants

There is a 12-month waiting period for transplants (except skin grafts); you become eligible to receive transplant services the first day of the 13th month you're covered under this plan. The waiting period will be reduced or eliminated based on prior coverage in a PacifiCare plan; the coverage must be continuous with no lapse greater than 63 days. Every month of prior coverage in a PacifiCare plan will reduce the 12-month waiting period by one month.

To receive transplant services, your PCP must obtain preauthorization from the participating medical group or PacifiCare.

Once the waiting period is satisfied and preauthorization obtained, the following transplant services are covered for a recipient:

- Clinical services for a living donor once the donor is identified (there is no dollar limitation for donor related clinical transplant services, but transportation and other non-clinical expenses of a living donor are not covered under this benefit; remember, all services/supplies must be medically necessary to be covered)
- Donor searches performed by a provider in the National Preferred Transplant Network (see the Glossary booklet)
- Non-experimental/non-investigational organ transplants and autologous and allogeneic bone marrow and stem cell transplants performed at a National Preferred Transplant Network facility (you may be accepted by two network facilities for organ transplant listings if the regional organ procurement agency for each facility differs; if this happens, coverage is limited to the actual transplant at the second facility; you're responsible for any duplicated diagnostic costs incurred at the second facility)
- Testing of your immediate blood relatives (sisters, brothers, parents or natural children) and unrelated donors identified through donor searches to determine donor compatibility.

If the National Preferred Transplant Network facility preauthorized by PacifiCare is more than 60 miles from your primary residence, additional services are covered for the recipient and one escort:

- Transportation
- Food (excluding liquor and tobacco) and housing, limited to $125 a day for both recipient and escort.

The transplant benefit does not cover:

- Anti-rejection medications (covered under prescription drug benefit)
- Care related to the transplant and received during the 12-month transplant waiting period (see "Preexisting Condition Limit")
- Donor costs when the donor is a plan participant but the recipient is not
- Experimental or investigational transplants
- Services for which government funding is available, other than Medicare, Medicaid or CHAMPUS
- Storage costs for any organ or bone marrow
- Tissue typing or matching for anyone other than the immediate blood relatives and identified unrelated donors described
- Transplants of mechanical or nonhuman organs
- Transportation or other non-clinical expenses of the living donor
- Transportation of any family members for typing and matching.

► Urgent Care

This plan covers urgent care for medical conditions that are not life threatening but may need immediate attention, for example:

- Ear infections

- High fever
- Minor burns.

If you need urgent care, call your PCP or Participating Medical Group (24-hour phone numbers are on the front of your ID card). If you call during non-business hours and a provider isn't immediately available, ask for the provider-on-call to be paged and call you back with instructions.

If your PCP, Participating Medical Group or provider-on-call is unavailable, seek services from any licensed medical professional and notify your PCP or Participating Medical group within 24 hours of receiving the services. Otherwise, if you, the hospital staff or someone else on your behalf does not contact PacifiCare within 24 hours, you may be responsible for all costs incurred before you call.

► Vision Care

The plan covers the vision care described in the "Summary of Covered Expenses," but does not cover:
- Any eye exam or corrective eyewear required by an employer as a condition of employment
- Any vision care services, supplies or treatment except as specifically described
- Any vision care services, supplies or treatment provided by another plan
- Contact lens fitting (K-reading) fees
- Initial lenses and/or frames provided in connection with post-cataract surgery
- Orthoptics or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes (which is a basic covered benefit for which you must be referred back to your PCP)
- Plain (non-prescription) lenses
- Replacement of lost or broken lenses or frames furnished through this plan (except at normal service intervals)
- Two pair of glasses instead of bifocals
- Subnormal (low) vision aids.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the PacifiCare plan does not cover:
- Acupressurist or homeopath procedures or those supplied by a Christian Science practitioner/sanitarium or rabbi
- Charges in excess of UCR rates (see the Glossary booklet)
- Child's pregnancy, including complications or termination
- Claims not made to PacifiCare within 12 months of the date of service (if you can't submit the claim on time due to circumstances beyond your control, PacifiCare will consider the claim for payment if you write and explain the circumstances)
- Conditions for which the Veterans Administration, federal, state, county or municipal government or any of the armed forces is responsible or provides treatment
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism except as required by law
- Convalescent or custodial care, no matter where it's given, or any part of a hospital stay that is primarily convalescent or custodial (this exclusion does not apply to home health and hospice care if part of an approved treatment plan)
- Cosmetic, plastic or reconstructive procedures furnished primarily to improve or change appearance (for example, breast enlargement or uplift except as specified, reshaping the nose/rhinoplasty, revising scars or keloids, surgery for sagging skin of the eyelids, face, neck, abdomen, hips or extremities) except the items listed under "Reconstructive Services," if preauthorized
- Court-ordered programs, services or supplies unless considered medically necessary by PacifiCare

- Dental care, except as described in "Injury to Teeth"; hospital care to extract teeth or for other dental care is not covered unless adequate care cannot be provided outside the hospital and an underlying medical condition requires hospitalization
- Educational or self-help training, except as described by the plan
- Elective or voluntary enhancement procedures, services, supplies or medications including, but not limited to:
  - Anti-aging
  - Athletic performance
  - Cosmetic purposes
  - Hair growth
  - Mental performance
  - Sexual performance
  - Weight loss
- Enteral therapy or nutritional supplements
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, school or recreational activities
- Experimental or investigational procedures (see the Glossary booklet)
- Foot care, such as:
  - Treatment of fallen arches or other symptomatic complaints unless associated with a disease affecting lower limbs
  - Prosthetics, appliances or orthotics connected with or inserted in shoes or impression casting for them (unless associated with diabetes)
  - Trimming of nails, corns or calluses (unless associated with diabetes)
- Habilitative therapy for hyperkinetic syndromes of childhood
- Hearing aids or costs related to their fitting and upkeep
- Jaw augmentation or reduction (orthognathic surgery), except when medically necessary
- Methadone, except when used in conjunction with an approved inpatient detoxification program
- Obesity procedures such as weight control programs, surgery or its complications or wiring of the jaw
- Orthoptics
- Procedures that are:
  - Covered under motor vehicle medical or no fault coverage, personal injury protection or similar insurance (this exclusion does not apply to uninsured motorist or underinsured motorist insurance coverage)
  - Furnished by a provider not licensed, registered or certified to perform them as required by the state where the provider is practicing
  - Not covered by the provider's malpractice insurance
  - Not medically necessary for the diagnosis, treatment or prevention of injury, unless otherwise noted
  - Obtained without referral or preauthorization if required from your PCP, participating medical group or PacifiCare
  - Outside the scope of the provider's license, registration or certification
  - Performed by a provider related to you by blood, marriage, adoption or legal dependency
  - Received while you're not covered, for which no charge is made or for which a charge is available only because this plan is in effect, except as required by law
- Prescription or non-prescription drugs, or medicines for outpatient use, including take-home drugs from inpatient stays, other than those covered under the specific prescription drug benefit of this plan; the plan does not cover food items (except PKU formula), over-the-counter items or prescription drugs that are not preauthorized (if preauthorization is required)
- Prescription medication to treat sexual dysfunction, including erectile dysfunction, impotence or anorgasmy, or hyporgasmy
- Radial keratotomy or any surgery to change the cornea's refractive character or complications from the surgery
- Reproductive or sexual disorders or defects (whether or not the consequence of illness, disease or injury) such as:
  - Artificial insemination or in vitro fertilization
  - Reversal of sterilization

  - Treatment for:
    - Frigidity
    - Infertility (fertility/sterility studies or procedures to restore/enhance fertility are not covered)
    - Impotence
    - Sexual reassignment
- Temporomandibular joint (TMJ) disorders
- Vision analysis, therapy or training relating to muscular imbalance of the eye
- Work-related illness or injury (unless you're a LEOFF 1 employee and workers' compensation has been denied).

Coordination of Benefits

► Coordination of Benefits Between Plans

If you or your dependents are covered under another health plan, PacifiCare coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by PacifiCare will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is always called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plans pay benefits in this order (unless there is a court decree establishing financial responsibility for the child's health care):
  - The plan of the parent with custody
  - The plan of the spouse of the parent with custody
  - The plan of the parent without custody
  - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

► Coordination of Benefits With Medicare

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary)
- Discontinue your county medical coverage and enroll in Medicare; if you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► What to Do

If you receive care from a PacifiCare network provider, the provider submits claims for you. If you receive emergency services from a non-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to PacifiCare or have the provider submit one for you. Claim forms are available from PacifiCare (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:
- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:
- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number (shown on your PacifiCare ID card and available from Benefits and Retirement Operations)
- Date, time, location and brief description of accident if treatment is the result of an accident.

Submit a claim within 90 days, or as reasonably possible, of receiving service/supply; the plan will not pay a claim submitted more than 12 months after the date of service/supply. (If you can't meet the 12-month deadline because of circumstances beyond your control, the claim may be considered for payment when accompanied by a written explanation of the circumstances.)

PacifiCare will make a determination within 30 days from the date you submit a complete claim. PacifiCare will not pay for any excluded service/supply unless authorized by your PCP, the participating medical group or directly by PacifiCare. Any payment assumes you've not exceeded your benefit limits; if you've reached or exceeded any applicable benefit limit, these bills will be your responsibility.

► If the Claim Is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim Is Denied

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that PacifiCare reviewed in making the determination.

If You Have a Problem

► Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility

If a properly filed claim or treatment preauthorization request is denied in whole or in part, PacifiCare notifies you and your provider with an explanation in writing. When a claim/request is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim/request is denied for eligibility reasons, follow the steps described in "Appealing Claims or Treatment Preauthorization Requests Denied Due to Eligibility."

If you or your representative disagrees with a claim/request denial, you may try to resolve any misunderstanding by calling PacifiCare and providing more information (see the Resource Directory booklet). If you'd rather communicate in writing or the issue isn't resolved with a call, you may submit an appeal either orally or in writing by contacting PacifiCare within 180 calendar days of receiving an initial claims/request determination.

You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial claims/request determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal.

Your appeal is reviewed by an individual who is neither the individual who made the initial claims/request determination nor the subordinate of that person. If the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or used, the appeal determination is made by a medical reviewer health care professional who has the necessary education, training and relevant expertise in the field of medicine to evaluate the specific clinical issues that serve as the basis of your appeal.

PacifiCare reviews your appeal within a reasonable time appropriate to the medical circumstances and makes a determination within 30 calendar days of receiving the appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response:

- Includes the specific reason for the decision
- Describes the criteria, guidelines or benefit provision on which the denial was based
- Explains that, upon request, you may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based.

If your appeal involves an imminent and serious threat to your health (including, but not limited to, severe pain or the potential loss of life, limb or major body function) it is immediately referred to PacifiCare's clinical review personnel. PacifiCare immediately informs you of your review status in a written statement of the disposition or pending status of the expedited review no later than three calendar days from receiving your appeal.

Experimental or Investigational Treatment. A claim or treatment preauthorization request may be denied because Pacificare determines the treatment is experimental or investigational. If your provider certifies you have a terminal illness (an incurable or irreversible condition with a high probability of causing death within a year or less) and the requested service or procedure would be significantly less effective if not promptly initiated, you may request a conference within 20 business days of receiving the denial.

Non-Binding Arbitration. You have the right to submit to arbitration under the commercial mediation rules of the Judicial Arbitration and Mediation Systems. There is no charge for this service; however, the decision is not binding to either party. To initiate this, contact PacifiCare.

► External Review for Denied Appeals

If an appeal of a denied claim or treatment preauthorization request is denied, or PacifiCare fails to respond to your appeal within the timeframe described in "Appealing Claims or Treatment Preauthorization Requests Denied

for Reasons Other Than Eligibility," you may request an external, independent review. The review is provided by the Independent Review Organization (IRO), a group of providers qualified to determine the medical necessity of treatment. The IRO is under contract to the Washington State Department of Health and not materially affiliated with PacifiCare. There is no charge for the external review process, once you've exhausted the appeal process.

To request an external review, you, your provider or your designated representative must submit the request to PacifiCare (see the Resource Directory booklet) within 180 days following your appeal denial. Within three business days of receiving your request, PacifiCare forwards it to the IRO with:

- All relevant medical records and other documents used by PacifiCare to decide your case
- All information or evidence submitted by you and your provider, including any additional information you think is relevant that may not have been included with your denied appeal.

Neither you nor PacifiCare may meet with the IRO provider or otherwise participate in the provider's decision.

Within 25 business days of receiving all review request materials (within eight business days if your provider certifies the requested service or procedure would be significantly less effective if not promptly initiated), an IRO provider or panel of providers (if deemed appropriate by the IRO) makes a decision. If the IRO providers need more information to make a decision, this time period may be extended.

The IRO provides you and PacifiCare with a written copy of its decision, a description of the provider qualification and any other information deemed appropriate. If the final external decision is to approve payment or preauthorization, PacifiCare will accept the decision and cover the service or procedure according to plan terms and conditions. If the final review decision is that payment or preauthorization should not be made, PacifiCare is not obligated to coverage the service or procedure.

For more information about this external, independent review process, contact PacifiCare (see the Resource Directory booklet).

► Quality of Care Complaints

To submit quality of service complaints, including those requiring clinical review, contact PacifiCare.

Complaints affecting your current condition are reviewed immediately. PacifiCare conducts this review by investigating the complaint and consulting with your participating medical group, treating providers and other PacifiCare departments. Medical records are reviewed as necessary; you may need to authorize their release.

PacifiCare notifies you in writing regarding quality of care issues within 30 calendar days of receiving your complaint. Results of the review are confidential and protected from legal discovery under Washington State law.

If a claim for benefits or reimbursement is part of your quality of care complaint, the claim is reviewed through the appeals process described in "Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility."

► Claims Against Participating Medical Groups, Etc.

Claims against participating medical groups, the group's physicians, providers or hospitals (other than claims for benefits under your coverage) are not governed by the terms of this plan; you may seek any appropriate legal action against those persons and entities deemed necessary. However, in the event of such a claim, PacifiCare makes available the appeals process for resolution. If you and the other party agree to follow the PacifiCare appeals process to resolve your claim:

- All parties must agree to this resolution process
- Any decision reached through the appeals process is not binding upon the parties unless the parties agree
- Resolution of the claim is not subject to binding arbitration unless the parties agree
- If the grievance isn't resolved, you and the other party may seek any appropriate legal action deemed necessary.

► Appealing Claims or Treatment Preauthorization Requests Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim or treatment preauthorization request denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 14 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you're eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to PacifiCare within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from PacifiCare (see the Resource Directory booklet).

Extension of Coverage

If this plan is canceled, PacifiCare will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends on the date of discharge or when the participant reaches the plan maximums, whichever comes first.

Payment of Benefits

The medical benefits offered by this plan are insured by PacifiCare, meaning this is not a self-funded plan. PacifiCare is financially responsible for claim payments and other costs.